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CONSUMER TASK FORCE
AUGUST 26, 2008

OFFICE UPDATE

FY09 LTC APROPRIATIONS - POWERPOINT PRESENTATION BY JOANNE BUMP

DCH DECISION DOCUMENT - SUSAN STEINKE

AFFORDABLE ASSISTED LIVING - TIM MCINTYRE

LTC FOR POST RELEASE PRISONERS - POWERPOINT PRESENTATION BY ROB CURTNER

PROJECT UPDATES

OFFICE OF LONG-TERM CARE SUPPORTS & SERVICES
Update for the Consumer Task Force
August 26, 2008

BUDGET - JoAnne Bump will provide a summary of the budget.

GRANT UPDATES - Attached

OFFICE UPDATES: - The Office is in the process of re-organizing. There will be three sections:

- Evaluation and Quality Improvement- Pam McNab
- Systems Transformation - Jane Alexander
- Data Analysis - to be determined

LONG-TERM CARE INFORMATION FORUM - The LTC Information Forum was July 31, at the Capitol View Building. It was well attended by over 80 people. The topics included home help, nursing facility case mix reimburesment, State Profile Tool grant, and MI Choice Quality Management. The next forum is scheduled for October 30, 9am - noon, at the Capitol View Building, Conference Rooms A-C. Topics to be determined.

NEW GRANTS -

- Joe Longcor is working on the next continuation grant for the Medicaid Infrastructure Grant.

- Rob Curtner is working on a grant that would fund the ground work for the "single point of exit" from prisons. To be discussed later in the agenda.

LONG-TERM CARE SUPPORTS AND SERVICES ADVISORY COMMISSIONB - Gloria Lanum is the support person for the Commission. Any questions should be directed to her. LanumG@michigan.gov

Michigan Department of Community Health

Presentation of FY 09 Appropriation for Long-Term Care Services

Joanne Bump
August 26, 2008

Office of Long Term Care Supports and Services

Key Changes

- Unified LTC appropriation line to support flexibility in implementing services

  Final Action: Did not support

- “Rebalance” with expansion of community care offset by lower Nursing Facility utilization

  Final Action: Support in part

- Redirects resources based on savings to assist rebalancing

  Final Action: Support in part

What Is Rebalancing?

- Expanding and/or reinvesting to extend array of LTC options, to promote individual choice
- Most citizens prefer to obtain LTC assistance in their home and community as long as possible
- Federal mandates:
  - Centers for Medicare & Medicaid Services
  - Deficit Reduction Act
  - Olmstead Supreme Court Decision (1999)
  - President’s 2002 New Freedom Initiative

Single Points of Entry

- Support the continuation of four Single Point of Entry demonstration projects as required by PA 634 of 2006
- Four demonstration sites covering 52% of population were initiated in FY 07
- Promote informed choice about options available to meet long-term care needs
- Streamline access to services; assist with use of individual resources

SPE Activity Through July 2008

Activity	Through February 2008
Information & Assistance	48,854
Options Counseling Cases	8,588
Assist transition from NF residence	209
Level of Care Determinations	9,520
Resource Data Base	3,600

Program for All-Inclusive Care for the Elderly (PACE)

- PACE is managed health and long-term care for frail elders (Medicaid and Medicare) $4.05 million was appropriated.
- Includes expansion of PACE into Muskegon and Calhoun counties
- Adds to PACE option now available in Wayne and Kent counties
- Will serve 161 elders

Affordable Assisted Living (AAL)

- $1.3 million was appropriated for waiver services for ~ 50 people
- Partner project with MSHDA
- Allows “aging in place” for elders
  - When needs increase, waiver services maintain person in his/her apartment
  - Offers additional housing option for NF transitionees
- AAL can provide, if necessary, round-the-clock monitoring and assistance
- A “Housing with Services” model
- Six prototype projects are all within SPE areas
- SPE’s provide a “front door” for services access

Specialized Residential Care

- $2.8 GF-GP was appropriated for developing a new waiver option
- 85 slots in licensed Adult Foster Care or Homes for the Aged to support special needs care
- For consumers needing 24 hr support and supervision that cannot be provided at home
- Adds home and community based services option that most states now have
- Targeted for development within SPE areas
- Can provide community option for those otherwise requiring NF care

MI Choice Waiver Wait List

- $10 million was appropriated to address ~15% of MI Choice Wait List population
- Supports ~ 485 new MI Choice participants
- Allows MI Choice Wait List to be reduced
- 12% of Wait List population die or enter a NF during their wait
- Expansion targeted:
  - One-half in SPE areas
  - One-half in non-SPE areas

FY 09 Sources of Nursing Facility Savings Targeted For Reinvestment

- "Level of Care" (LOC) determinations are running at lowered rates when conducted independently by SPE's. This results in NF cost savings: $5.8 million
- PACE expansion savings: $10.4 million
- FY 08 & FY 09 transitions from NFs requiring minimal or no Medicaid LTC services: $16.2 million

Money Follows the Person CMS Grant

- Transition services for “individuals – in residence at least 6 months
- MFP grant supports MI Choice services: transferred $4.3 million to Waiver
- Projected reduction in NF services costs
- Based on NF transition trends and enhanced NF transition Pathway
- FY 09 target: 400 transitionees

Limit Nursing Facility Variable Cost Component

- Executive proposed to limit the NF rate increases to rate of inflation as determined by Centers for Medicare & Medicaid Services
- Fairness in rate increases compared to other providers
- Exec. Rec. held annual variable rate increase closer to the CMS “Market Basket” index (~ 2.5%)
- Exec. Rec. reduced increase by ($31.3) million
- Final appropriation provided 4.9% increase for NF.

Increase the Quality Assurance Assessment Retainer

- Increases QAAP retained by state from $39.9 to $53.9 million in Sec. 1809
- Save general fund by increasing the retainer
- Would “lock in” retained revenue at 14.9% by statue.

Other Key Actions

Action	Gross Cost
Annualize Minimum Wage Increase to $7.50/hr.	$10.9 M
Correct GF under-funding of HCBS with transfer from LTC (NF) line	$2.0 M
OLTCSS Grants	$654,200
OLTCSS Staff Transfers	$508,800
Sec.1775 Study prepaid managed care Sec.1777 Permits dining assistants	

Subject: DCH Decision Document for CTF

This is the Senate Fiscal Agency's breakout of the MDCH Decision Document. Decision documents are the final decisions made by committees. In this case, it is the decision document of the DCH Appropriations Conference Committee. This is a very large document, so it is not attached. It can be found online at http://www.senate.michigan.gov/sfa/Departments/DecisionDoc/DDdch_web.pdf.

Here are some pages that may be of more interest to the CTF. The page numbers are located at the bottom of the pdf screen which are one number off from the actual page numbers.

Page 16: Refers to the 2% increase for direct care workers in CMH
Page 23: Refers to funding for the Criminal Background Checks in Nursing Facilities
Page 29, #69: Refers to the Traumatic Brain Injury (TBI) pilot projects
Page 36, #85: Refers to the increase in care management dollars used by Area Agencies on Aging
Page 41, #92e: Refers to the transfer of long term care funding to MIChoice
Page 43, #95: Refers to the annualization of the Home Help provider wage increase
Page 46, #99a: Refers to the Nursing Home Variable Cost Rate
Page 50, #100: Refers to the use of savings from reduced utililzation of nursing homes being used for the expansion of home and community based services and PACE (the Program of All-Inclusive Care for the Elderly). This is continued on page 51
Page 52, #101b: Refers to the long term care managed care proposal
Page 53, #101e: Refers to the Home Help Health Care Trust (which was not funded)
Page 54, #101g: Refers to the increase in the personal care services rate in Adult Foster Care homes
Page 124, #136: Has more information on the TBI pilots
Page 171, #231: Details the reporting around the MIChoice waiting and priority lists
Page 172, #232: Requires reports on quality indicators in MIChoice and Home Help
Page 172, #233: Has more information on the Home Help provider wage increase
Page 174, #237: Refers to the Nursing Home Case Mix Workgroup
Page 191, #277: Refers to the Money Follows the Person reporting
Page 192, #278: Refers to the report on LTC managed care

DYNS SERVICES

MI Affordable Assisted Living – Fact Sheet 8/08

- Michigan will join more than forty states in developing Affordable Assisted Living (AAL) as a new long Term Care (LTC) option. Approximately $1.3 million is budgeted to secure a Medicaid waiver to initiate AAL programs in 2009.
- AAL will provide apartment style housing with Medicaid and other community based services for persons who can no longer remain home and those who prefer to live in residences with available LTC supports and services. AAL is also an option for current nursing home residents to transition back to the community and receive less costly LTC services.
- The project was initiated from a Michigan State Housing Development Authority (MSHDA) formed work group exploring *Aging in Place* issues.
- MSHDA and the Michigan Department of Community Health (MDCH) along with the Department of Human Services and the Office of Services to the Aging have been planning the project for well over a year. The state partners designed an AAL demonstration project and selected 5 proposals from housing developers and local service providing agencies.
- AAL demonstration sites are to be located in Battle Creek, Detroit, Grand Haven, Grand Rapids and Menominee. The first site, Heron Manor, is located in Grand Rapids and will be accepting tenants in February 2009.
- A state level AAL Steering Committee has been working on developing the demonstration project since August 2007. DYNS Services, Inc. serves as the technical assistance contractor, with MSHDA & MDCH funding, to coordinate the development of the initiative.
- The Committee is defining AAL as a new component in the existing LTC system that integrates housing with services and expands consumer LTC opportunities. The Steering Committee is utilizing the following statement as the philosophy to drive decisions about AAL physical design and the scope of services: *to provide a community based long term care program in a home-like apartment style residence that facilitates self direction, person centered planning and managed risk to maximize tenant independence, dignity, privacy and aging in place in an accessible environment.*
- The AAL Steering Committee has committed to a number of important values and decisions relevant to consumer choice; including choice in providers and supports coordinators and consumer input on the method of on-site provider selection, the providers to be selected and in measuring provider performance.

LTC FOR POST-RELEASE PRISONERS

Presentation Purpose:

- To position post release LTC services in the context of national and state perspectives.
- To identify promising directions and methods.
- To pose questions that help connect with MDoC and possible grant sources.

Contents:

- National Context
- Michigan Context
- Pre-Release Planning
- Questions Regarding Need for LTC Services for Post-Release Offenders

National Perspective - 1

- The lexicon of the correctional field now includes:
  - post-release planning,
  - discharge planning,
  - inmate reentry,
  - continuity of care,
  - community-oriented corrections health model,
  - and transitional health care.

National Perspective - 2

- The recent emphasis on postrelease planning is based in the reality that the correctional system does not have a rehabilitative effect.
- On average, 62% of released state prisoners are rearrested within 3 years and 41% are reincarcerated (Beck, 2000).
- Large urban jails face even higher reincarceration rates. In New York City, for example, 40% of the 80,000 inmates discharged annually are readmitted within 12 months (New York City Department of Corrections [NYC DOC], 2005).

Source: Journal of Correctional Health Care /

Vol. 14, No. 1, January 2008

National Perspective - 3

- The high rate of rearrest and reincarceration is a strong indicator that nearly half of the released inmates are not positively reintegrating into their home communities.
- In other words, if rearrest and reincarceration rates are the standard measure of success, then the current process is failing.
- A coordinated discharge planning process may help decrease the number of readmissions.

National Perspective - 4

- Though inmates still suffer physical injuries, a high proportion have a host of health, behavioral, and social problems that precede their incarceration.
- Eighty percent used drugs before their arrest, 13% have a mental health problem, 19% are illiterate and 40% functionally illiterate, 31% were unemployed before arrest, 2% to 3% have HIV/AIDS, and 18% are infected with hepatitis C
- In New York City, 40% of the jail inmates require mental health services during their incarceration (with 29% diagnosed as seriously mentally ill), 30% report being homeless within 3 months before incarceration, 75% have a history of substance abuse, 20% require detoxification on admission, and 32% are functionally illiterate

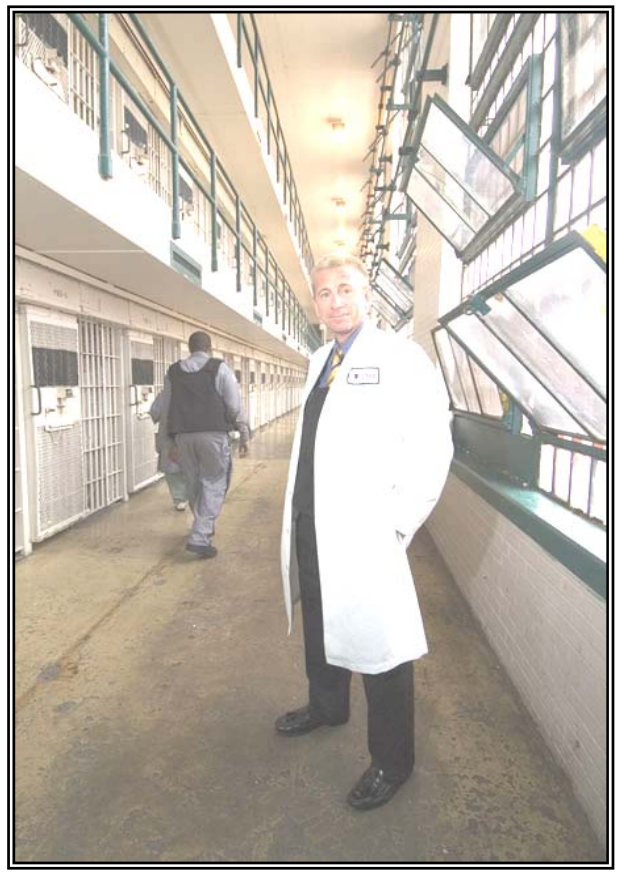
National Perspective - 5

- Another practical reason for developing discharge plans is the potential positive effect on the public health and safety of the community.
- Ninety-three percent of all inmates are eventually released from prison; some would argue that they return to their communities with more severe health problems than when they were incarcerated (Massoglia, 2006; Petersilia, 2005).
- Others disagree. What is known is that released inmates account for a large percentage of the population with health problems, communicable disease in particular.

National Perspective - 6

- Data exist that suggest that early intervention and provision of services that directly meet the needs of released inmates can be a method of proactive problem solving that attempts to deal with problems or issues before former inmates violate parole or are arrested for a new offense

  (Aos, Phipps, Barnoski, & Lieb, 2001).



National Perspective - 7

- Ultimately, a successful discharge plan requires that an optimal level of services is available and coordinated to ensure a continuum of care and treatment during the reentry process (Queralt & Witte, The Evolving Standard of Decency / *Mellow, Greifinger* 1999).
- There are data that support the proposition that preparing inmates for return to their community and linking them to community services and supports benefits the health and safety of both the individual and the public (Freudenberg, Daniels, Crum, Perkins, & Richie, 2005).

National Perspective - 8

- Several states with comprehensive prerelease programs have preliminary data that indicate reduced recidivism rates for those who complete a discharge program compared with those who elect to be released without any programming (Finn, 1998; Nelson & Trone, 2000).
- However, recidivism rates are not the sole litmus test for health and public safety.
- Success can be measured by the number of ex-inmates employed, enrolled in treatment, testing negative for drug use, adhering to their medication, and having stable housing.

National Perspective - 9

- In *Wakefield v. Thompson* (1999), a correctional officer refused to give Wakefield a 2-week prescription of a psychotropic medication on his release from prison, even though it was ordered by the medical staff to continue treatment to control his delusions.
- Without medication, 11 days after his release he had an episode of violence as a result of his illness.
- He was rearrested. The court determined that Wakefield's constitutional rights were violated because "a prisoner's ability to secure medication on 'his own behalf' is not necessarily restored.
- When a prisoner walks through the prison gates and into the civilian world, the state has a duty to provide a parolee with medication for his immediate post-release period.

Michigan Prisoner Re-Entry Initiative (MPRI)

- Michigan is a leader in prisoner re-entry and is the first state in the nation to converge the three major schools of thought on prisoner re-entry to develop and fully implement a comprehensive model of prisoner transition planning.
- The MPRI Model begins with the three phase re-entry approach of the Department of Justice's Serious and Violent Offender ReEntry Initiative (SVORI);
- It further delineates the transition process with the seven decision points of the National Institute of Corrections' Transition from Prison to Community Initiative (TPCI) model;
- and incorporates into its approach the policy statements and recommendations from the Report of the Re-Entry Policy Council coordinated by the Council of State Governments.
- In this way, the MPRI represents a synergistic model for prisoner re-entry that is deeply influenced by the nation's best thinkers on how to improve parolee success.

Table 1: The Three-Phase, Seven-Decision-Point MPRI Model

PHASE ONE—GETTING READY

The **institutional phase** describes the details of events and responsibilities which occur during the offender's imprisonment from admission until the point of the parole decision and involves the first two major decision points:

1. ***Assessment and classification*:** Measuring the offender's risks, needs, and strengths.
2. ***Prisoner programming*:** Assignments to reduce risk, address needs, and build on strengths.

PHASE TWO—GOING HOME

The **transition to the community or re-entry phase** begins approximately six months before the offender's target release date. In this phase, highly specific re-entry plans are organized that address housing, employment, and services to address addiction and mental illness. Phase Two involves the next two major decision points:

3. ***Prisoner release preparation*:** Developing a strong, public-safety-conscious parole plan.
4. ***Release decision making*:** Improving parole release guidelines.

PHASE THREE—STAYING HOME

The **community and discharge phase** begins when the prisoner is released from prison and continues until discharge from community parole supervision. In this phase, it is the responsibility of the former inmate, human services providers, and the offender's network of community supports and mentors to assure continued success. Phase Three involves the final three major decision points of the transition process:

5. ***Supervision and services*:** Providing flexible and firm supervision and services.
6. ***Revocation decision making*:** Using graduated sanctions to respond to behavior.
7. ***Discharge and aftercare*:** Determining community responsibility to "take over" the case.

MPRI Performance

- As proof of performance that the MPRI, 65.1% of the MPRI and IRU cases paroled through November of 2007 had a history of prior parole failure, while only 34.5% of the 1998 baseline paroles had a history of prior parole failure.
- When controlling for history of prior parole failure, the overall MPRI/IRU recidivism outcomes through November of 2007 currently show a 26% improvement in total returns to prison against the 1998 baseline (across all of the release cohorts as a group.)
- This translates into 493 fewer returns to prison so far when compared to baseline expectations
- The numerical reduction that will grow considerably if these results are sustained over a full three-year follow-up period.

Conclusion to Prison Health Care Senate Fiscal Agency Report from September, 2000

- When compared with other states, in the self-reported survey published in the *Corrections Compendium,* Michigan appears to spend more than other states do on prisoner health care services.
- Based on surveys of surrounding states, the higher cost may result from Michigan's provision of more mental health care capacity than other states provide and the unique relationship between the DCH and the MDOC in providing prisoner mental health care services.
- The managed care contract for hospital and specialty services appears to have contained medical care costs, which were at an all-time high prior to the signing of the contract.
- However, appropriations for hospital and specialty care will continue to increase as the price accelerator moves the expenditure per prisoner higher. Also, as more medical services become part of a contract with a per-prisoner cost, the cost of providing care to one additional prisoner should be higher than it is when excess capacity can be used to serve the additional prisoner.
- Moreover, the mounting complexity of care needed for the prison population will continue to grow as the proportion of the HIV/AIDS-infected and elderly populations in the prison population continues to increase.

Prison Health Care, Senate Fiscal Agency Report from September, 2000

- The MDOC's health care services are appropriated in three parts. One part is appropriations for 20 clinical complexes that provide on-site, basic medical services to the prisons and prison camps.
- In the 1980s, Michigan entered into two consent decrees under Federal court supervision, commonly called Hadix and USA. The consent decrees cover many conditions, among which are fire safety, hygiene, and protection from harm at specific facilities: Michigan Reformatory, Marquette Branch, and Jackson Prison.
- In addition, the consent decrees address system-wide issues including medical and mental health care.
- In 1991, the State entered a third consent decree, called Glover, dealing with female prisoners.

Prison Health Care, Senate Fiscal Agency Report from September, 2000

- Today, some of the portions of the consent decrees have been terminated whereas other portions remain in place.
- All costs for the consent decrees, even terminated portions, are appropriated separately from other institutional costs in a subunit called consent decrees.
- The line items within the subunit identify the consent decree or the service provided.
- In 1997, a managed care contract was awarded to United Correctional Managed Care, Inc. Subsequently, the contract was transferred to Correctional Medical Services (CMS). In 1999, a revision to the CMS contract extended its term through April 1, 2003, and added an accelerator to the per diem contract rate. In April 2000, the contract was revised to include service providers.

Prison Health Care, Senate Fiscal Agency Report from September, 2000

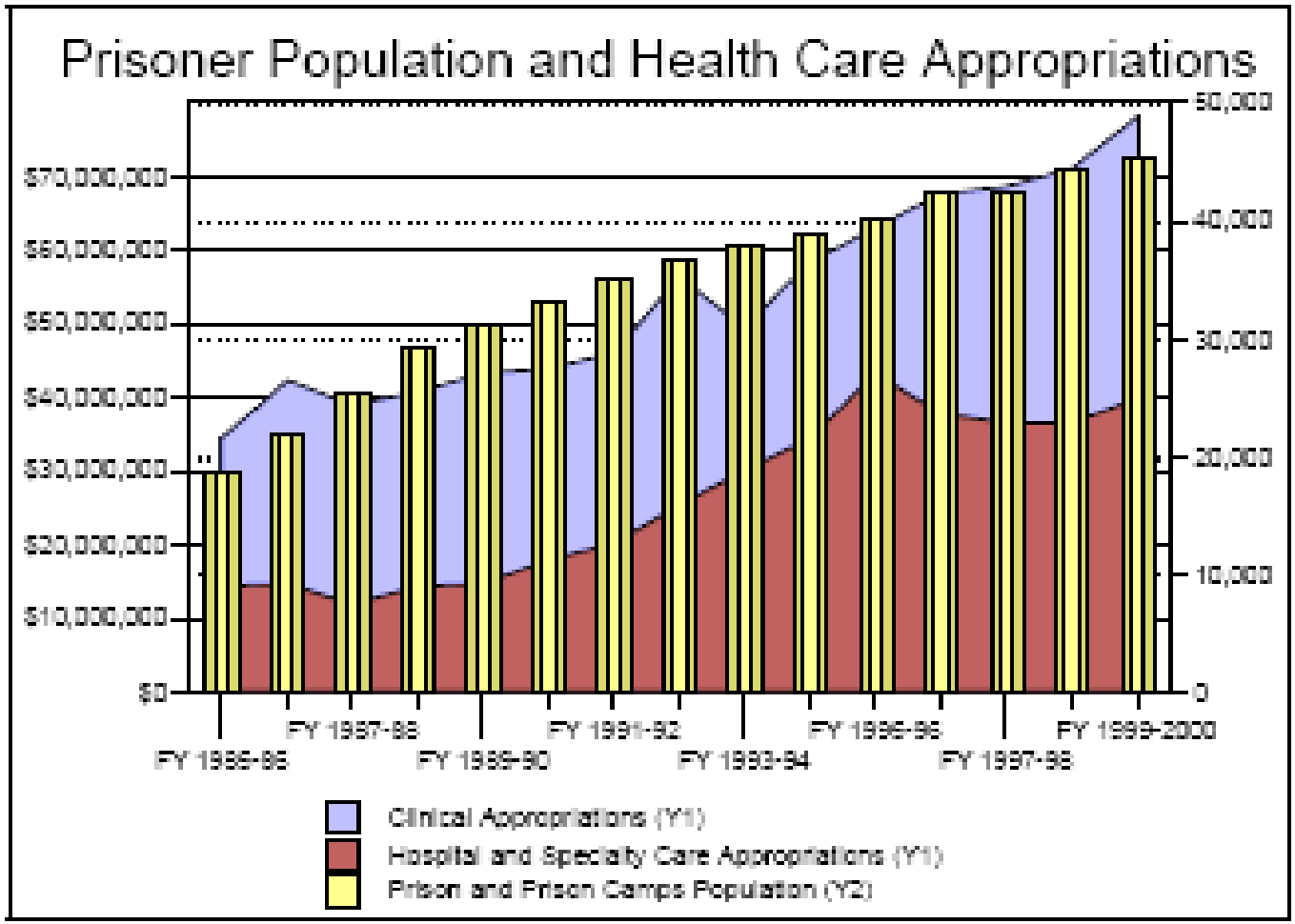
- These services include the provision of prescribed medicine, sick call, basic dental services, and regular checkups for prisoners with chronic conditions.
- Dialysis and pharmaceuticals are appropriated in these line items.
- Another part is a line-item appropriation for hospital and specialty care which includes care that cannot be provided on-site and major medical care.
- The third part is the mental health services appropriated in the consent decree subunit and paid directly to the Michigan Department of Community Health (DCH), which operates the program.

Prison Health Care, Senate Fiscal Agency Report from September, 2000

- Looking at the medical health care portions, Figure 1 shows that, as the prison population has grown, the appropriations for the clinical complexes and the hospital and specialty care portions of the health care system also have increased. In total, the appropriations for medical health care have grown from $48.7 million in FY 1985-86 to $118.0 million in FY 1999-2000, or 142.2%.
- In the same time period, the population has grown from 18,800 to 45,200, or 140.4%.
- The growth of the appropriations for hospital and specialty care at 179.1% has far exceeded the growth of the prison population, whereas the growth rate of clinical care at 126.7% has been slightly lower than the prison population growth.
- In FY 1995-96, when the MDOC contracted with United Correctional Managed Care to provide managed care services for hospital and specialty care, the appropriation for hospital and specialty care decreased, as seen in Figure 1.

Prison Health Care, Senate Fiscal Agency Report from September, 2000

Figure 1



Prison Health Care, Senate Fiscal Agency Report from September, 2000

- 7 long-term care beds and 4 short term care beds at Marquette Branch Prison, 16 long-term care beds at Huron Valley Men's Facility, and 26 chronic care beds at Duane L. Waters Hospital in Jackson.
- The number of special needs beds does not equate to the number of prisoners who appear to be in need of special care. Some lower-level needs prisoners are accommodated in barrier-free beds at other facilities that are not in proximity to medical care and food service.
- Some able prisoners are given work assignments in which they care for disabled prisoners. Some higher-level needs prisoners are placed in community facilities where security is provided.

Prison Health Care, Senate Fiscal Agency Report from September, 2000

- The fastest growing age groups in Michigan prisons are those over 40 years of age. As the baby-boom moves through the age groups, the growth of this segment should continue, not just because prisoners will age in place, but because the age of admission to prison will increase.
- Although being elderly alone does not account for additional medical costs, with the number of prisoners in their 70s and 80s increasing, health care costs, such as those provided to the elderly in the general population, will continue to increase.

Prison Health Care, Senate Fiscal Agency Report from September, 2000

Table 2

AGE OF PRISONERS IN INSTITUTIONS

	1990	1991	1992	1993	1994	1995	1996	1997	1998	Change 1990-1998
<20	1,566	1,620	1,413	1,172	1,317	1,375	1,583	1,559	1,500	-4.2%
20-29	14,950	15,552	16,071	15,587	15,517	15,150	15,482	15,894	15,693	5.0%
30-39	11,583	12,382	13,378	13,769	14,228	14,375	14,565	15,282	15,433	33.2%
40-49	4,270	4,822	5,538	5,923	6,614	7,326	7,903	8,781	9,343	118.8%
50-59	1,475	1,637	1,877	2,098	2,323	2,522	2,754	3,195	2,699	83.0%
>60	411	454	521	560	578	649	715	817	890	116.5%

Source: Department of Corrections Annual Statistical Report 1990 - 1998

Prison Health Care, Senate Fiscal Agency Report from September, 2000

- The NIC survey found that health care system costs are related to the method of service delivery, the use of capitation, and the number of prisons in a given prison system.
- With the exclusion of Michigan, Hawaii, Indiana, Maine, Montana, and Nevada, the NIC researchers found that in 1998, the average covered prison population was 24,217 prisoners and that the average annual health care cost per inmate was $2,610.
- Appropriations for the medical portion of Michigan's health care for an average covered prison population of 42,500 equated to $2,475 per year in FY 1997-98.
- Michigan's per annum rate reported by the MDOC in the *Corrections Compendium* is $4,150, suggesting that mental health care costs were $1,675 per prisoner per year, or about two-thirds of the cost of medical care.

Prison Health Care, Senate Fiscal Agency Report from September, 2000

- Michigan's prisoner mental health care was developed, in part, under the supervision of the Federal courts through consent decrees. Mental health care costs are appropriated in the consent decree subunit including costs for MDOC security personnel and other staff, and an amount that is paid to the DCH based on billings from that Department.
- In FY 1999-2000, the total appropriation for mental health care in the consent decree subunit was $83.6 million, with $68.9 million for mental health services and $14.7 million for security.
- For FY 2000-01, the appropriation increased to $86.8 million, with $71.4 million for mental health services and $15.4 million for security.
- Based on prison population estimates from the MDOC, the appropriations equate to $1,819 per prisoner per year in FY 1999-2000 and $1,835 per prisoner per year in FY2000-01.

GAO Study on Sex Offenders in NF's

- By analyzing the FBI's NSOR, which is a compilation of sex offender registries submitted by all states, GAO identified about 700 registered sex offenders living in nursing homes or ICFs-MR during 2005.
- Most identified sex offenders were male, under age 65, and living in nursing homes, and represented 0.05 percent of the 1.5 million residents of nursing homes and ICFs-MR.
- About 3 percent of nursing homes and 0.7 percent of ICFs-MR housed at least 1 identified sex offender during 2005.
- However, these estimates are understated due to data limitations.

Supreme Court Ruling on Correctional Health Care

- From the court's decision in *Estelle v. Gamble* (1976), the first Supreme Court case dealing with correctional health care.
- To quote the court, "the infliction of such unnecessary suffering [failure to treat an inmate's serious medical needs] is inconsistent with contemporary standards of decency" (*Estelle v. Gamble*, 1976, p. 5).
- Although *Estelle* is remembered for the court's determination that deliberate indifference is the standard of review for constitutional violations concerning alleged correctional health care maltreatment, another legacy of *Trop v. Dulles* and, subsequently, *Estelle v. Gamble* is the recognition that society's changing legal and ethical interpretation of decency dramatically influences correctional agencies in their policies and practices when implementing post-release planning and transitional health care.

Supreme Court Ruling on Correctional Health Care

- At the present time, only a small minority of state prisoners are engaged in a comprehensive and formalized prerelease program. In 1997, for example, only 10% of prisoners discharged received any prerelease planning (Angiello, 2005).
- The majority of the current discharge programs are voluntary and available primarily in minimum-security prisons (Austin, 2001). To our knowledge, there are no published data of current discharge planning from jails nationwide.
- In a study of continuity of care for mentally ill inmates in jails, 49% of the 379 inmates in the study, located in seven separate city and county facilities, received a discharge plan before release (Veysey, Steadman, Morrissey, & Johnsen, 1997).
- The study, however, did not assess the quality of the discharge plans. Thus, comprehensive postrelease planning and continuity of care is still in its infancy.

Unanswered Questions

1. Over the next 10 years, how many Medicaid nursing facility eligible individuals with LTC needs are likely to be released from Michigan Correctional Facilities?
2. What is known about the acuity and potential for community living for these individuals?
3. What is the expected cost of Medicaid Services to provide services to these individuals?
4. What cooperative planning is possible between OLTCSS and MDOC to identify and plan for community living or NF care?
5. Are enhancements to pre-discharge planning are possible which would facilitate transition to successful LTC in community settings?

CONSUMER TASK FORCE

UPDATE OF PROJECTS

JULY 2008

STATE PROFILE TOOL GRANT
AUGUST 2008

MPHI continues to work on filling in the draft outline of the Profile. We met with Mental Health and Substance Abuse regarding the information we need. We are, for the most part, obtaining the information we need to complete the State's profile.

We met with MDRC on the Advisory Council. MDRC sent invitation letters to be a part of the Council and we developed a meeting schedule and strategy. There are five meetings planned. There will be a preliminary meeting for consumers. A presentation will be provided on the meeting topics for consumers to become familiar with the topics. The Advisory Council will meet the next morning. The first Advisory Council meeting was Friday, August 15, on mental health issues. Many thanks to MDRC and specifically Carolyn Lejuste and Teresa Christmas!

SYSTEMS TRANSFORMATION GRANT (STG)
AUGUST 2008

The Systems Transformation Grant is basically to provide continued funding to existing initiatives such as Person-Centered Planning and Self-Determination. Therefore, the progress report for the STG is included in the specific grant reports.

LONG-TERM CARE PARTNERSHIP
AUGUST 2008

CMS has tied approval of the State Plan Amendment for this program to estate recovery. There continues to be correspondence back and forth between MSA and CMS, but no approval yet. Until the State Plan Amendment is approved, further work on this project is stalled.

Medicaid Infrastructure Grant (MIG) Update:
August 2008

There are presently 1085 Freedom to Work (FTW) participants.

Medical Services Administration (MSA)/MIG joint meeting was held on August 19. Interviews for the position to address transitioning people through informed choice from AD Care to FTW has started. MI Job Coalition representatives Tony Wong and Jill Gerrie met with MSA on August 19 about a possible FTW amendment. Unrelated to this work; Representative Schuitmaker's Office also contacted Tony Wong to discuss how to address improving FTW.

Joe and Marty now report to Patty Degnan with DCH at Lewis Cass on Walnut St. Their offices will remain at Long-Term Care for awhile until space opens up at Lewis Cass.

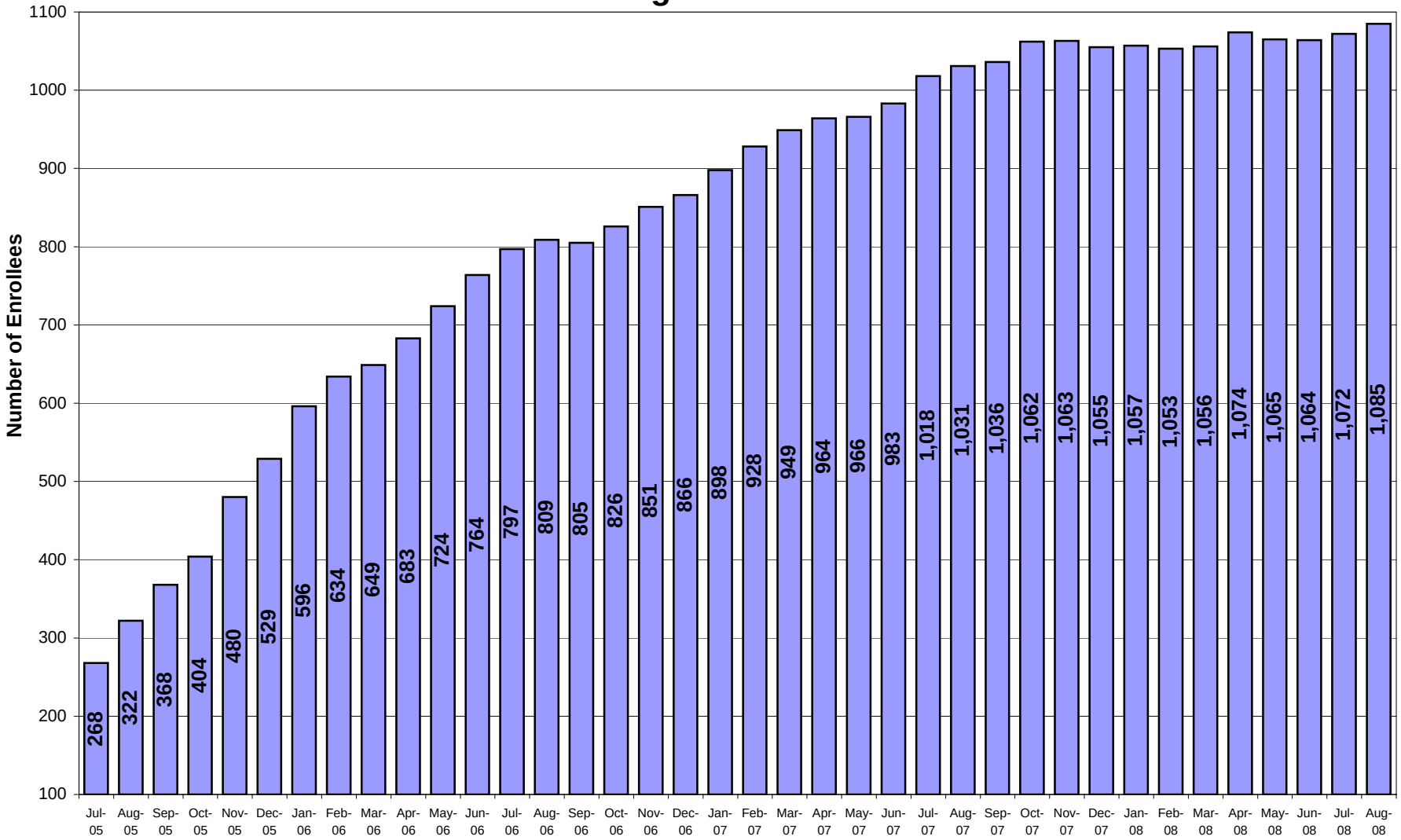
Joe has been preparing the 2009 MIG Continuation report & grant due August 25. This will reflect activities and outcomes since the 1st of January and build on the current work emphasis areas of:

- Increasing competitive supported employment
- Coordinating statewide initiatives for Project Search
- Amending/changing FTW
- Addressing spend-down
- Strengthening benefits planning/work incentives utilization
- Developing a "benefits-to-work 101.org" web portal and related calculators
- Evolving business leadership networks across MI
- Researching a possible "curriculum" on disability & employment associated with universities and community colleges

Marty, Su Min Oh, and Joe will be attending the National Consortium for Health Systems Development (the MIG's TA provider) in Chicago September 3 and 4.

County Code	County Name	COUNT Beneficiary ID		County Code	County Name	COUNT Beneficiary ID
1	Alcona	3		41	Kent	104
2	Alger	1		44	Lapeer	8
3	Allegan	13		45	Leelanau	1
4	Alpena	5		46	Lenawee	14
5	Antrim	4		47	Livingston	5
6	Arenac	3		49	Mackinac	1
7	Baraga	1		50	Macomb	62
8	Barry	6		51	Manistee	6
9	Bay	33		52	Marquette	11
10	Benzie	2		53	Mason	4
11	Berrien	28		54	Mecosta	8
12	Branch	6		55	Menominee	5
13	Calhoun	17		56	Midland	15
14	Cass	5		58	Monroe	16
15	Charlevoix	6		59	Montcalm	1
16	Cheboygan	2		60	Montmorency	2
17	Chippewa	13		61	Muskegon	42
18	Clare	4		62	Newaygo	7
19	Clinton	5		63	Oakland	96
20	Crawford	2		64	Oceana	4
21	Delta	9		65	Ogemaw	2
22	Dickinson	8		66	Ontonagon	1
23	Eaton	20		67	Osceola	3
24	Emmet	3		69	Otsego	11
25	Genesee	32		70	Ottawa	23
27	Gogebic	4		71	Presque Isle	1
28	Grand Traverse	24		72	Roscommon	2
29	Gratiot	3		73	Saginaw	8
30	Hillsdale	7		74	St. Clair	14
31	Houghton	9		75	St. Joseph	9
32	Huron	6		76	Sanilac	4
33	Ingham	45		78	Shiawassee	13
34	Ionia	2		79	Tuscola	6
35	Iosco	1		80	VanBuren	5
36	Iron	4		81	Washtenaw	37
37	Isabella	5		82	Wayne	99
38	Jackson	12		83	Wexford	4
39	Kalamazoo	62			TOTAL	1,072
40	Kalkaska	3				

Michigan FTW Enrollees
August 2008



Update to Consumer Task Force
Michigan Long-Term Care Supports and Services Advisory Commission
Meeting Date of July 28, 2008

The July meeting of the Long-Term Care Supports and Services Advisory Commission was held in Grand Rapids, Michigan hosted by Holland Home.

Commissioner Reardon, board chair of the Health Care Association of Michigan, announced that HCAM has a new President and CEO. David LaLumia joined the organization as of July 14, 2008.

Jan Hudson, Senior Planning and Research Associate of the Michigan League of Human Services, provided a presentation on the State of Michigan's structural budget deficit titled "Putting Michigan's Budget in Perspective." Ms. Hudson provided an update about where Michigan resources will come from to deliver quality long-term care services, maintaining an array of supports and services, and what has changed regarding the structural deficit given the state of our economy.

Public comment addressed issues of balancing wages for home health workers, housing discrimination against seniors and improving housing choice, consumer first person nursing facility experience, promoting the need and value of senior centers, better assistance for senior abuse, and the successful implementation of the West Michigan LTC Connection.

Paul Bridgewater, Executive Director, Detroit Area Agency on Aging, Karen Watson, Project Manager, Detroit Area Agency on Aging, and Betsy Rust from Plante Moran presented on the Detroit Nursing Facility Quality Project. The project will work to address a crisis issue of nursing home closures in the City of Detroit. The study, findings, and strategies of the project were discussed.

Commissioner Chesny, Finance Workgroup Co-Chair, reported that the Workgroup has taken up two major topics: case mix reimbursement and long-term care insurance, specifically the Partnership Program. The Workgroup recommended that the Commission become actively engaged and participate in the Department's LTC Partnership Program.

Peggy Brey, Interim Director, Office of Long-Term Care Supports and Services provided a presentation on Fiscal Year 2009 budget, and legislative action to increase long-term care supports and services.

The next meeting of the Michigan Long-Term Care Supports and Services Advisory Commission is September 22, 2008 in Detroit.

Prepared by Gloria Lanum, Office of Long-Term Care Supports & Services, MDCH
August 19, 2008

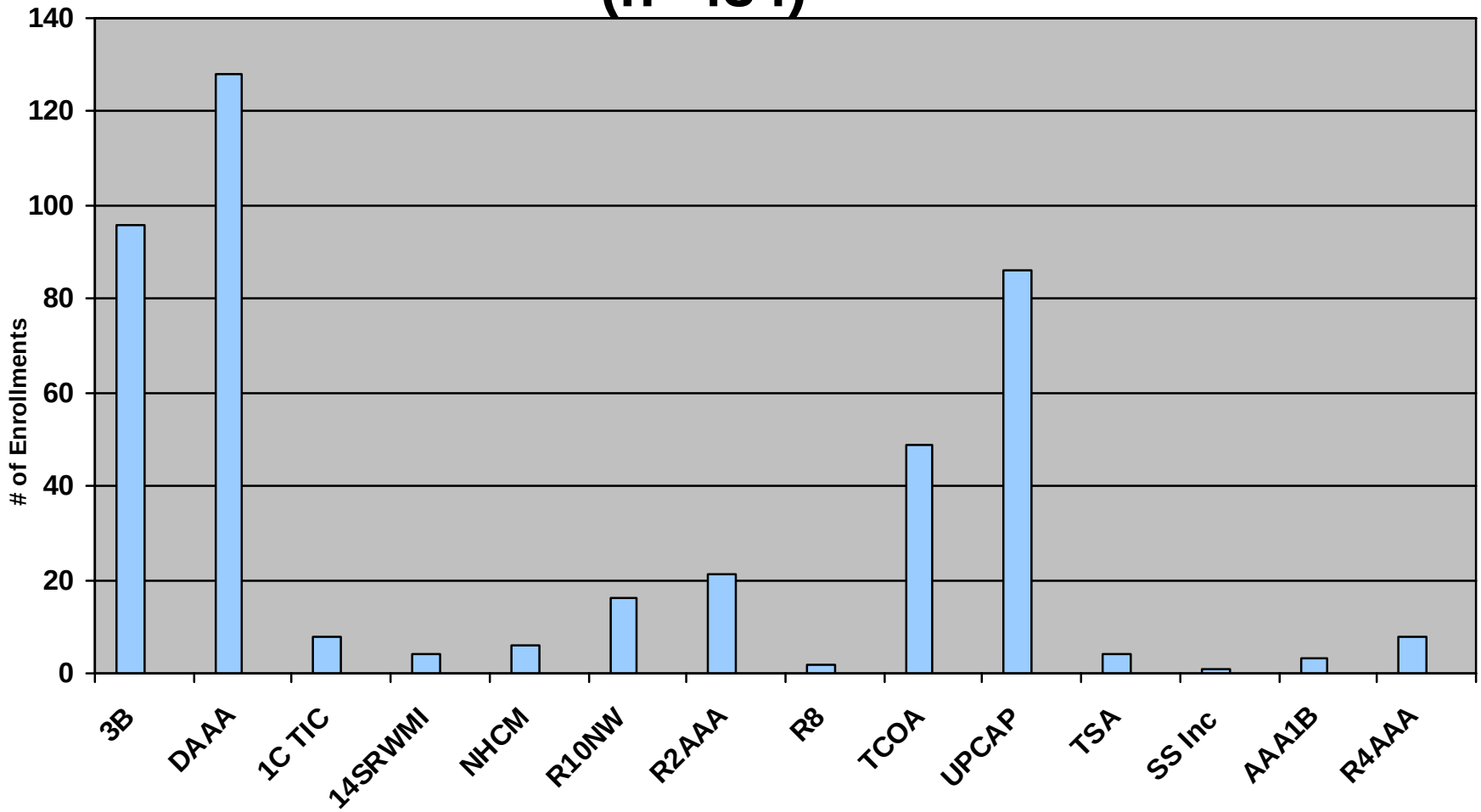
Summary of Long Term Care Connection Activities July 2008

	SWMLTCC	WMCLTCC	DWCLTCC	UPLTCC	Totals
I and A Calls					
Long Term Care Contacts	1033	601	751	171	2556
Contacts Referred to Options Counselors	152	105	349	208	814
Total Contacts	1185	706	1100	379	3370
Resource Database					
Resource availability by county/city	800	2072	326	706	3904
Options Counseling Cases					
Options Counseling Cases Opened	75	108	462	115	760
Cases Closed	59	71	437	124	691
Cases Continuing Open	530	977	2241	608	4356
Level of Care Determinations	227	322	421	172	1142
Community Education Presentations					
Number of Presentations	11	1	2	252	266
Number Present	114	12	1950	153	2229
Outreach Activities					
Number of Activities	23	5	5	3	36
Number of brochures distributed	317	1500	107	650	2574
Stakeholder Meetings					
Number of Meetings	15	3	21	2	41
Number of Participants	18	4	30	30	82
Partnership agreements	0	49	0	0	49
Board Meetings					
Number of Meetings	0	0	0	1	1
Number of Total Board Members	10	7	13	8	38
Number of Board Members Present	NA	0	NA	6	6
Consumer Advisory Board Meetings					
Number of Meetings	1	1	0	1	3
Number of Total Consumer Advisory Board	14	10	27	10	61
Present	5	9	NA	6	20

Summary of Long Term Care Connection Activities July 2008

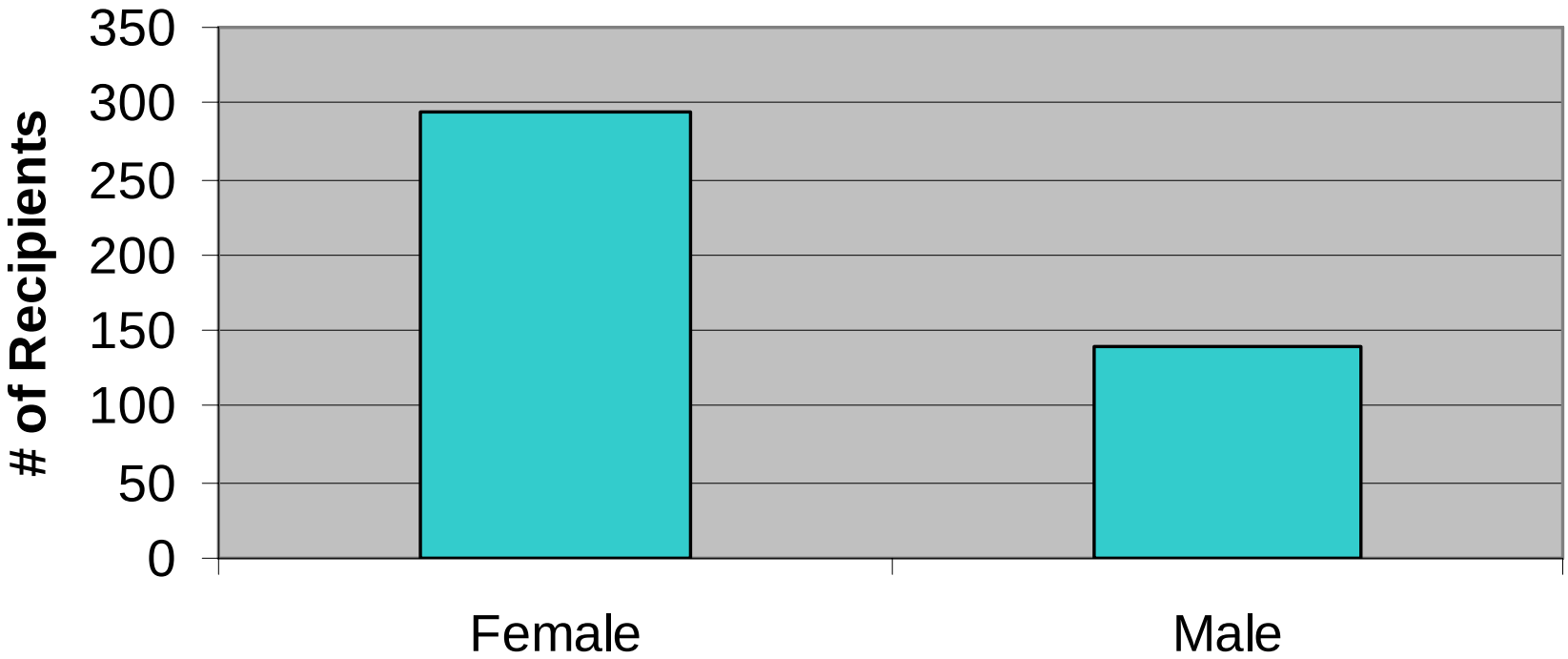
	SWMLTCC	WMCLTCC	DWCLTCC	UPLTCC	Totals
Nursing Facility Transitions					
Transferred to Waiver	22	3	15	5	45
Transferred to CIL	39	0	1	1	41
Transitioned by LTCC					
Opened	63	0	16	19	98
Completed	5	0	0	4	9
Continuing	15	0	7	33	55
Requests for Emergent Services	1	0	91	1	93

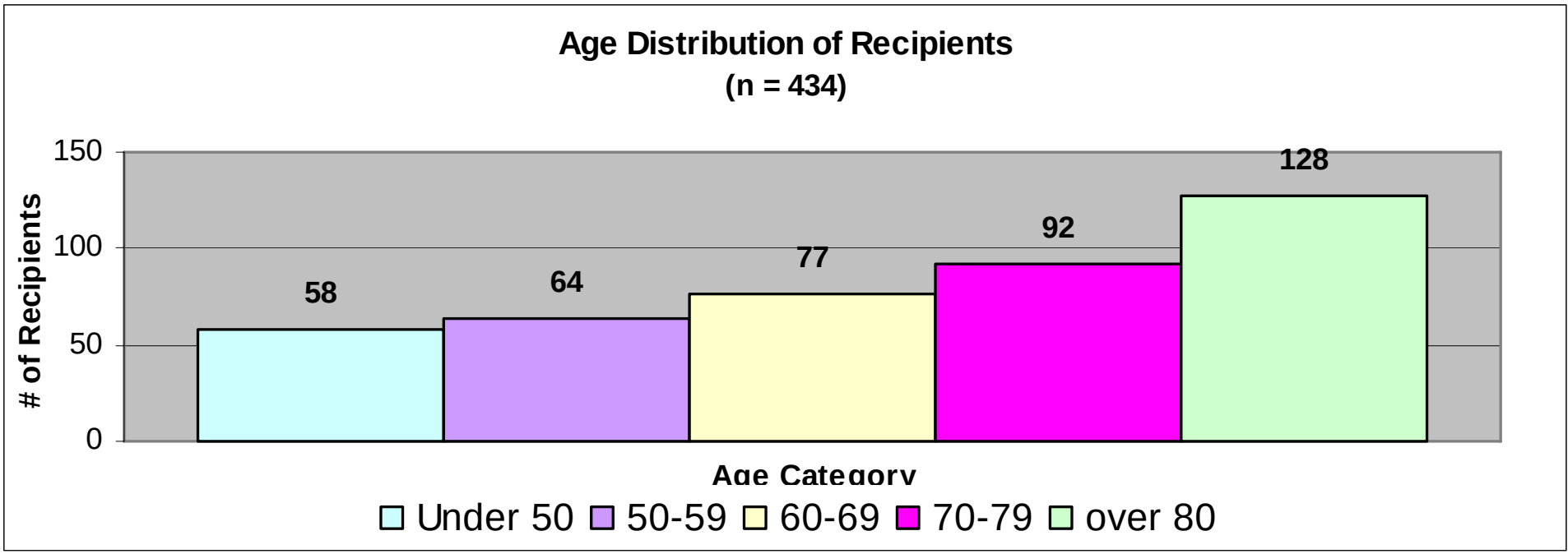
Number of Enrollments by Waiver Agent (n=434)



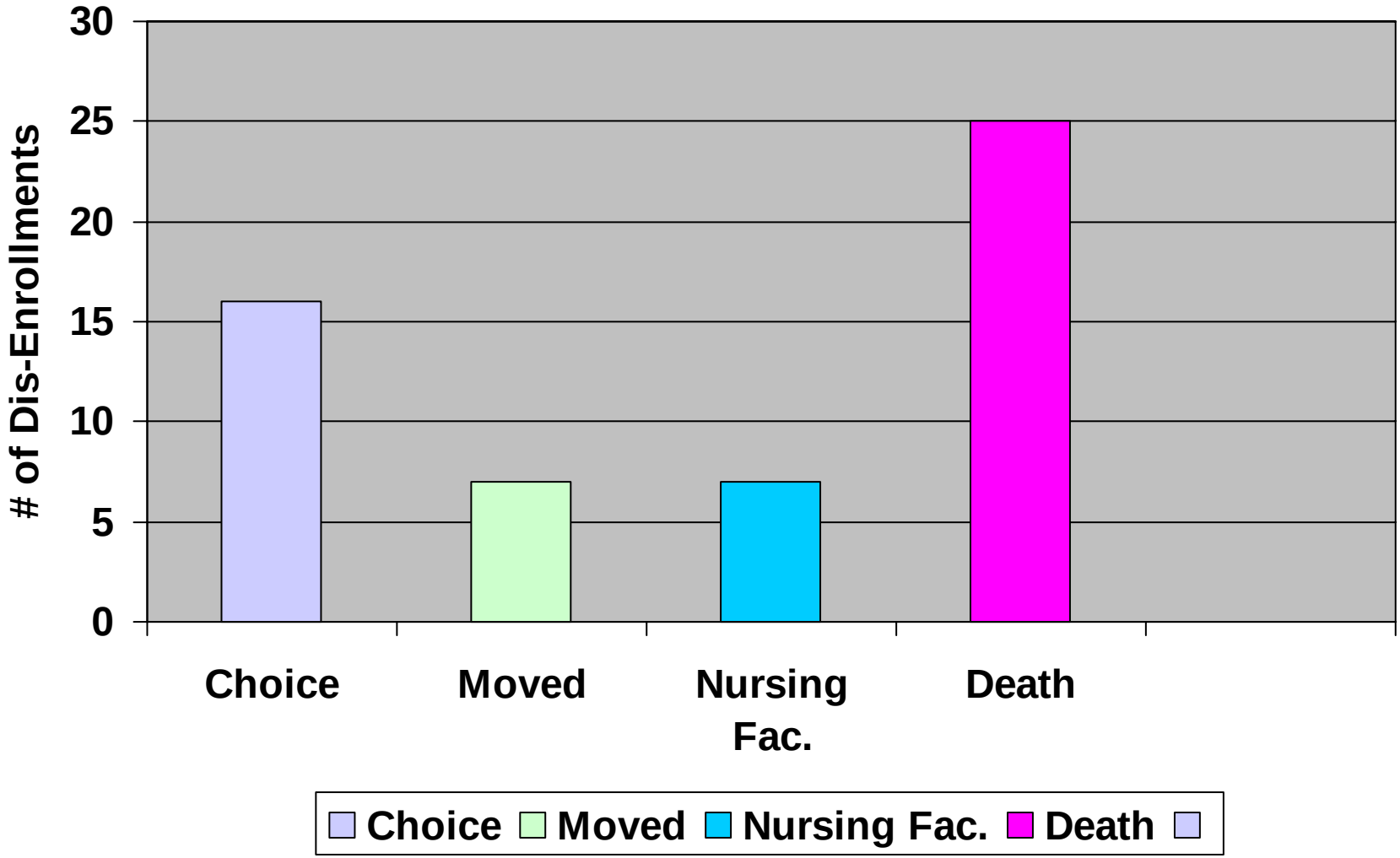
August 25, 2008

Recipients by Gender




Age Distribution of Recipients
(n = 434)
150
100
50
0
# of Recipients
58
64
77
92
128
Age Category
Under 50
50-59
60-69
70-79
over 80

Number of Dis-Enrollments



August 25, 2008

Waiver Agents

- **NHCM**……..6 Enrollments
- **14SRWMI**……4 Enrollments
- **R10NW**……16 Enrollments
- **3B**……..96 Enrollments
- **R2AAA**……21 Enrollments
- **AAA1B**……3 Enrollments
- **R4AAA**……8 Enrollments
- **R8**……..2 Enrollments
- **TCOA**……49 Enrollments
- **TSA**……..4 Enrollments
- **UPCAP**……86 Enrollments
- **DAAA**……128 Enrollments
- **SS Inc**.....1 Enrollment
- **1- C TIC**……8 Enrollments

WAIVER AGENTS YET TO ENROLL

- MORC
- REGION V
- REGION VII
- A&D HOME HEALTH
- HHS
- NMRH
- NEMSCA

MEDICAID LONG-TERM CARE SINGLE POINT OF ENTRY SERVICES PILOT PROJECTS

(FY2008 Appropriation Bill - Public Act 123 of 2007)

April 30, 2008

Section 1686: (1) The department shall submit a report by April 30, 2008 to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies on the progress of 4 Medicaid long-term care single point of entry services pilot projects. The department shall also submit a final plan to the house of representatives and senate subcommittees on community health and the house and senate fiscal agencies 60 days prior to any expansion of the program.

Michigan Department of Community Health

MDCH

Jennifer M. Granholm, Governor

Janet Olszewski, Director

Michigan Department of Community Health
Status Report on Michigan's Long-Term Care Connections

(Formerly named Single Point of Entry Demonstration Projects)
April 30, 2008

Section 1686 (1) of Public Act 123 of 2007 requires a report on the progress of Long-Term Care Single Point of Entry pilot projects. The Long - Term Care Connection (LTCC) was established as a result of the Governor's Executive Order 2005-14, in order to implement recommendations made by the Governor's Medicaid Long-Term Care Task Force. The responsibilities of the pilots have been defined by P. A. 634 of 2006 around specific goals. Given resource limitations, these goals are being phased - in over time with each step establishing a base to build upon for the future. (See Table 1.)

Table 1 - LTCC Progression

Description	Date
Governor's Long-Term Care Task Force	May, 2005
Governor's Executive Order 2005-14	June 2005
Appropriation and contracts developed	July 2006
SPE's were named Michigan's Long-Term Care Connections	Sept. 2006
Start up of Information and Assistance	Oct. 2006 to Jan. 2007
Signed PA 634	Jan. 2007
Start up of Options Counseling	Jan. to April 2007
Level of Care Determinations	Nov. 2007
Digital Data system (MIS)	In development

Access to Information, Assistance and Services – The LTCC has established **1-866-642-4582** as the toll free phone number that was required by P. A. 634 of 2007. Information and assistance has been provided in over 35,600 contacts from January, 2007 to March, 2008. Satisfaction survey results reported from October, 2007 through mid March, 2008, the most recent available, indicate consumers were more than satisfied with the information and how the LTCC provided it as shown in Table 2.

Goal #1: Provide consumers, caregivers, and stakeholders with comprehensive information on long-term care options for current and future planning.

Table 2- Information and Assistance Consumer Survey

Question	% Agree
Received information I wanted	84.5
Information was clear	86.2
Information was accurate	81.5
Information was helpful	82.1
Understood the information received	89.2
Person was knowledgeable	89.2
Person was friendly	95.9
Person treated me with respect	95.3
Person listened carefully	94.0
Helped in reasonable time	90.9
Satisfied with assistance	81.9
Would call again	91.6
Would recommend service	91.6

Demographic information on the 12,102 LTCC consumers from October 2007 to March of 2008 provides a picture of the people using the service. Females represent at least 60 percent of the total, and more than 73% are age 60 or over. Information on the income levels is more difficult to acquire, especially on the initial contact, but we know that 43% were enrolled in Medicaid already or below poverty levels. The disability types reported include 15.2% with dementia, 51.1% with physical issues and 17.9% with more than one disability, illustrating that the LTCC staff needs to take adequate care to ensure that the caller's need for services is understood.

Personalized Support For Understanding And Planning -- The LTCC has developed a comprehensive on line resource data base with over 3,500 providers. This data base includes for profit providers as well as agency and government entities. The LTCC has made over 217 presentations to over 22,500 persons to give them the help they need for long term care planning in using their own resources, finding the help they want and controlling their own budget from January, 2007 to March, 2008.

Goal #2: Consumers explore and understand long-term care options with guidance from unbiased counselors to reach informed decisions that best meet their needs and preferences.

Navigating the System To Find Solutions -- The LTCC's have established uniform, consistent standards, procedures and protocols to determine functional eligibility. Medicare and Medicaid benefits available to individuals are reviewed and understood for their particular situation. Consumers learn about the costs for care services and settings while learning to make the most of their resources, delaying the need for Medicaid. From October, 2007 to March, 2008 a total of 3,691 consumers received options counseling. This LTC support plan may include: personal history and strengths, individual preferences and wishes, functional needs and health, financial and benefits status, informal supports from family, friends, neighbors and current services, unbiased detailed information on an array of options, including but not limited to service environment, quality, risks, limitations, and capacity, goals and actions, and an evaluation of how available long term care options meet the identified goals.

Goal #3: Consumers receive options counseling to understand eligibility for long term care services, care settings, licensing, and financing.

Table 3 indicates the results of a survey of those receiving options counseling. Options counseling may vary with the goals of the consumer. Some consumers are planning options for the future while others require services without delay. The survey indicates that consumers were more than satisfied with the outcome. The LTCC counselor was knowledgeable, listened carefully and treated them with respect.

Table 3- Options Counseling Consumer Survey for April, 2008

Question	% Agree
Received information I wanted	100.0
Information was accurate and gave me choices	100.0
Counselor was knowledgeable, listened carefully and treated me with respect	100.0
Helped me understand my care options	95.7
Helped me take steps to carry out plan	95.2
Helped in reasonable time	95.6
Discussed ways to pay for services	81.9
Helped with eligibility for LTC services	95.3
Satisfied with assistance	95.7
Would call again	91.3

Starting November 1, 2007, P.A. 634 of 2006, Sec. 109i.(17) required that the LTCC's conduct the level of care assessments for Medicaid functional eligibility to long term care programs within their regions, encompassing thirty-four Michigan counties and portions of Wayne County. Previously, nursing facilities and home and community based waiver agents made eligibility

decisions for clients within the LTCC region. This new determination process is independent of the provider to ensure good decisions by the consumer. The LTCC has conducted over 5,063 Level of Care Determinations (LOCD) from November, 2007 through March, 2008. The LOCD rate when conducted independently by LTCC's is lower than previous trends resulting in an estimated nursing facility cost savings of ($5.8) million gross in FY 09.

With the creation of the LTCC, the aged and disabled have an ally as the LTCC works with providers such as the nursing facility, waiver, and community. The LTCC's have forged partnership agreements by establishing them in over 75% of MI Choice Waiver and nursing facilities in the 4 regions. This partnership method ensures distinct roles that are streamlined and seamless so that people don't get lost in the system.

Emergent Cases - Of the over 16,217 Information and assistance contacts between October 2007 and March, 2008, 134 consumers faced an urgent need for long term care placement over the same time period. The definition includes a situation, defined by the consumer, as a long term care need requiring immediate attention.

In over 50% of the cases, immediate support was needed from the LTCC for services such as options counseling or a LOCD, home delivered meals and the state Medicaid Waiver program. Table 4 indicates how the consumers learning about the availability of urgent help.

Table 4 Emergent Cases

Referral From:	% of Cases
Community Agency	23.1%
Doctor or health professional	7.5%
Family, friend or neighbor	7.5%
Nursing Facility	23.9%
Hospital	5.2%
Community supports*	6.0%
Other	9.7%
Unknown	17.2%

*Community supports include HFA/AFC/Assisted living, subsidized housing, internet, radio, television, senior center and school.

Hospital Cases - The hospital discharge planner has continued in their role of facilitating the movement of the patient to either the nursing facility or community where the LTCC can follow up so that the timeliness of the discharge is not impacted. Out of the 3,691 total option counseling (OC) cases opened from November, 2007 to March, 2008, hospital referrals resulted in 17 option counseling plans or 0.5 percent of total OC cases during the same period.

Consumer Makes Informed Decision -- Consumers achieve control with the right information, at the right time to make their decisions. The Options Counselor works with the consumer to help them understand their options and make choices. As shown in Table 3, they were helped to understand their care options, ways to pay for care and carry it out within a reasonable time frame. Consumers receive support and assistance in paper work, allowing Medicaid to process requests more quickly. Over 256 persons have been assisted with the transition from nursing facility back to the community. Persons who contact the LTCC are receiving the

Goal #4: Consumers make informed choices for residential settings and care services that best meet their needs and preferences based on objective information, counsel and support.

assistance the demonstration program was designed to provide. Consumers are making informed choices, have streamlined access and increased control.

TOPIC	COMMENTS	LTC TASK FORCE	PA 634	SYSTEM TRANSFORMATION GRANT	Other Grants	Boiler Plate
Person Center Planning and Choice and Control and Self Directed	Self Determination is included as MFP in Finance as well as here with PCP.	**Recommendation # 1: Require and Implement Person-Centered Planning Practices. Strategy 1: Require implementation of person-centered planning in the provision of LTC services and supports. Include options for independent person-centered planning facilitation for all persons in the LTC system.**	**Sec. 109i** 2(b) That consumer assessments and support plans are completed in a timely, consistent, and quality manner through a person-centered planning process and adhere to other criteria established by this section and the department of community health. e) Assist consumers in developing their long-term care support plans through a person-centered planning process ~~(~~f) "Person-centered planning" means a process for planning and supporting the consumer receiving services that builds on the individual's capacity to engage in activities that promote community life and that honors the consumer's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the	**Goal 2. Increased choice and control: develop and enhance self directed service delivery system** **1. Develop person-centered planning** Strategy 1: Develop state-level practice guidelines: • Establish minimum standards and performance indicators directly related to PCP • Revise practice guidelines based on feed-back from broad-based review • Promulgate practice guidelines • Develop a roll-out strategy for the practice guidelines • Distribute practice guidelines according to roll-out strategy • Identify resources for sustainability of practice guidelines are Strategy 2. Develop site review criteria for application of person centered		

TOPIC	COMMENTS	LTC TASK FORCE	PA 634	SYSTEM TRANSFORMATION GRANT	Other Grants	Boiler Plate
			consumer desires	practice guidelines. • Identify members and establish work group to develop review criteria • Perform assessment of existing criteria (state and national) • Draft review criteria • Field test criteria • Modify review criteria based on testing and evaluation • Modify provider agreements/contracts to require compliance. Strategy 3. Ensure that the State operates under a PCP process in all facets of the waiver operation. Apply the principals of PCP to: 1) individual identifies goals, needs and preferences; 2) developing and managing the plan to meet goals, needs and preferences; 3) managing risks; 4) planning for emergencies (contingency planning/back up); 5) developing the individual budget; and 6) apply monitoring strategies through the		

TOPIC	COMMENTS	LTC TASK FORCE	PA 634	SYSTEM TRANSFORMATION GRANT	Other Grants	Boiler Plate
				creation o Definitions for above six domains o Policy to implement the six domains o Monitoring system to ensure the application of the policy Strategy 4. Develop and implement multiple layers of training on person-centered planning to accomplish the shift in attitudes and practices necessary for a person-centered approach throughout the LTC system. (Complements Independence Plus grant.) • Develop training curriculum using: o Independent facilitation o Participant experiences/stories • Develop peer mentoring for PCP • Identify training methods (written manuals, web-based, CD, physical attendance, others) • Evaluate training and techniques with consumer/advocate involvement		

TOPIC	COMMENTS	LTC TASK FORCE	PA 634	SYSTEM TRANSFORMATION GRANT	Other Grants	Boiler Plate
				Strategy 5: Evaluate the implementation of person-centered planning to determine if goals of improving participant quality of life and system reform are achieved for individuals. • Develop participant surveys to obtain participant feedback on the PCP process and the quality of the LTC service delivery system • Identify work group of consumers, advocates and other stakeholders to research, draft and evaluate the survey • Research existing surveys (state and national) • Identify core elements of surveys and population/community specific elements • Develop participant survey • Field test survey • Conduct broad-based participant surveys • Collect data on findings, analyze and publish results Strategy 6: Evaluate the implementation of PCP to		

TOPIC	COMMENTS	LTC TASK FORCE	PA 634	SYSTEM TRANSFORMATION GRANT	Other Grants	Boiler Plate
				determine if goals for system reform are achieved system-wide. • Identify quantifiable measures • Identify outcome measurements in QM plan • Identify and reduce resource barriers that limit choice and control • Develop an effective and realistic strategy to measure outcomes • Include PCP requirements in contracts with waiver agencies • Include PCP measures in site monitoring protocols, case record reviews and consumer interviews • Include PCP implementation in peer mentoring conducted within Waiver		
				Objective 2: Develop individual budgeting Strategy 1: Develop state level guidance on the development and implementation of individual budgets Strategy 2: Develop and implement state level training and technical		

TOPIC	COMMENTS	LTC TASK FORCE	PA 634	SYSTEM TRANSFORMATION GRANT	Other Grants	Boiler Plate
				assistance on budget development to increase understanding of individual budgeting and how it supports the goals of system transformation.		
				Objective 3: Develop participant-employer options Strategy 1: Develop state level guidance on the Choice Voucher System and Agency with Choice models for direct employment of workers to facilitate successful participant direction Strategy 2: Develop and disseminate state level policy guidance on Fiscal Intermediaries as employer agents for participants directly employing workers. (employer agents)		
				Objective 4: Ensure self-directed supports Strategy 1: Provide training and informational materials on supporting successful participant direction that address misperceptions on liability issues and describe		

TOPIC	COMMENTS	LTC TASK FORCE	PA 634	SYSTEM TRANSFORMATION GRANT	Other Grants	Boiler Plate
				methods for supporting participants Strategy 2: Make State level policy changes that will support and remove barriers to participant direction Strategy 3: Provide state level guidance on supporting participant direction and how to address barriers		
		Recommendation #1, Strategy # 2 Revise health facility and professional licensing, certification criteria, and continuing education requirements to reflect a commitment to organizational culture change, person-center processes, cultural competency, cultural sensitivity and other best practices.				
	In Task force # 3SPE and # 7 Quality	Recommendation #1, Strategy # 3 Require all Single Point of Entry agencies to establish and utilize person-center planning in their operations. Review and refine practice guidelines and protocols as part of the first year evaluation of the SPE pilot projects.				
		Recommendation #1, Strategy # 4 Include person-centered planning principles in model legislation to amend the Public Health Code.				
		Recommendation #1, Strategy # 5 Early in the implementation process, ensure the provision of **training** on person-centered				

TOPIC	COMMENTS	LTC TASK FORCE	PA 634	SYSTEM TRANSFORMATION GRANT	Other Grants	Boiler Plate
		planning to long-term care providers, regulators, advocates, and consumers.				
	See also # 7 Quality	6. Require a continuous quality improvement process to ensure continuation and future refinement of person-centered planning in all parts of the system.				

TOPIC SPE	LTC TASK FORCE	Progress	Executive Order	PA 634	SYSTEM TRANSFORMATION GRANT	ADRC	Boiler Plate
	Recommendation #3 Designate locally or regionally-based "Single Point of Entry" (SPE) agencies for consumers of LTC and mandate that applicants for Medicaid funded LTC go through the SPE to apply for services	Done through contractsing, funding and MSA 07-45 for NF and Wavier (PACE not yet included)	Administer activities to implement the recommendations of the Task Force. 7. Oversee the implementation of the single point-of-entry demonstration programs required under Section VI.	**Sec. 109i** (1) The director of the department of community health shall designate and maintain locally or regionally based single point of entry agencies for long-term care that shall serve as visible and effective access points for individuals seeking long-term care and that shall promote consumer choice and quality in long-	**Goal 1: Improved Access to LTC Support Services: Development of a One-Stop System**	**Enhance consumer planning and informed decision-making, and facilitate access to services through pilot regional Aging and Disability Resource Centers/Single Points of Entry.**	**Sec 1686** The Department shall submit a report by April 30 progress of 4 medicaid ltc single pint of entry pilot projects. Final plan 60 days pror to expansion. Shall report by September 30 of the current fiscal year: total cost, total cost of each, total amount of Medicaid dollars saved, total number of emergent and length of time for placement, total number transfer from hospital to ltc and average length of time for

TOPIC SPE	LTC TASK FORCE	Progress	Executive Order	PA 634	SYSTEM TRANSFORMATION GRANT	ADRC	Boiler Plate
							placement,
					Objectives: 1a Provide awareness, information and Assistance Strategy: Expand SPE service network for state-wide.		
					Objective 2 Streamline multiple eligibility processes Strategy: Expand state-wide		
					Objective 3 Target individuals who are at imminent risk for admission to an institution		
	Benchmarks 1. SPE agencies initially established in three areas of the state within one year of the issuance of the Task Force report.	Established in four contract July 2005			Objectives: 1a Provide awareness, information and Assistance		
	2. SPE agencies established throughout the state within three years from the issuance of the Task Force	Legislation delays until one year after "final" report—which is due December 2008			Objectives: 1a Provide awareness, information and Assistance Strategy:		

TOPIC SPE	LTC TASK FORCE	Progress	Executive Order	PA 634	SYSTEM TRANSFORMATION GRANT	ADRC	Boiler Plate
	report.				Expand SPE service network for state-wide.		
	3. In the absence of the LTC Commission, DCH will convene a workgroup of consumers, advocates, providers, and DCH officials that will develop a more detailed list of criteria using the recommendations in this report as a foundation to be met by a SPE agency by July 30, 2005. The workgroup should also approve the regions	Done					
	4. DCH or the LTC administration will issue an RFP for early adopters (the first three local SPE agencies). The RFP should require local support and collaboration but not prescribe which agencies can apply as early adopters. The state needs to ensure the recommended agency can meet the standards set by the state. At the time	Done					

TOPIC SPE	LTC TASK FORCE	Progress	Executive Order	PA 634	SYSTEM TRANSFORMATION GRANT	ADRC	Boiler Plate
	the RFP is issued, MDCH or the LTC Administration should hold briefings for interested agencies on the components of the RFP.						
	5. DCH, or the LTC Administration, will evaluate early adopters to determine if they are achieving the anticipated results. Information gathered during this evaluation should be used in the development of other SPE agencies.	Detailed Logic model and evaluation plan, being implemented.					
	DCH, or the LTC administration, will develop preliminary quality assurance 6. guidelines in time for the RFP that will be issued for the first round of SPE development. This will allow applicants to respond to how they meet quality assurance expectations up front.	Done					

TOPIC SPE	LTC TASK FORCE	Progress	Executive Order	PA 634	SYSTEM TRANSFORMATION GRANT	ADRC	Boiler Plate
	7. The outside advocate is adequately funded to assure consumer access in all geographic SPE areas.	Advocacy provided through existing network of ombudsman, legal aid, and role of Options Counselors. OC are "outside" of provider role and control through contract requirements.					
	8. SPE agencies have local quality assurance boards composed of a majority of consumers, with representation by other stakeholders that are reflective of the communities in which they are located. Functions might include CQI, feedback to governing board, and LTC administration.	Done					
	9. Agencies responding to the RFP to be an SPE will have an appeals protocol written into their proposals.	Done					
	10. DCH or the LTC administration will	Done					

TOPIC SPE	LTC TASK FORCE	Progress	Executive Order	PA 634	SYSTEM TRANSFORMATION GRANT	ADRC	Boiler Plate
	assure that Medicaid Fair Hearing processes are made available to SPE participants.						
	11. An agency applying to be an SPE should be able to provide a qualified Information and Referral service (such as those certified by AIRS).	Done			Objectives: 1a Provide awareness, information and Assistance Strategy:		
	12. Hospital discharge planners will contact the SPE at admission to begin the process of assessing needs instead of at discharge.	Informal, more work currently through local stakeholder meetings is occurring.			Streamline multiple eligibility processes Objective 3 Target individuals who are at imminent risk for admission to an institution		
	13. Physicians will coordinate with supports coordinators and consumers to ensure the best outcomes for the consumer. Memoranda of Agreement will be created between hospitals and single points of entry to make this process as	Informal, more work currently through local stakeholder meetings is occurring.			Streamline multiple eligibility processes Objective 3 Target individuals who are at imminent risk for admission to an institution		

TOPIC SPE	LTC TASK FORCE	Progress	Executive Order	PA 634	SYSTEM TRANSFORMATION GRANT	ADRC	Boiler Plate
	smooth as possible						
	14. Consumers and their loved ones will have a clear idea of their options.	Done—evidenced through consumer surveys.			Objectives: 1a Provide awareness, information and Assistance Strategy:		
	15. An assessment system and process will be developed that: Includes a standard minimum intake screen that predicts need for the full array of Medicaid funded LTC programs and efficiently identifies areas for further evaluation a. Incorporates person-centered planning as the starting point for assessment and goal development. b. Implements specific evidence-based assessment protocols when triggered by the minimum intake screen. c. Includes a comprehensive	Initial assessment, preliminary and final long term support plan elements are identified in standards and LCCC conduct LOC. Caregiver assessment training and system in development—available in limited way through research project in UP and Detroit now. Service Point in use but not yet shared between providers.			Streamline multiple eligibility processes		

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	caregiver assessment when indicated. d. Utilizes an electronic database that serves as a base for information, documents assessment and planning history, and follows the individual through the full array of long-term care supports.						
	16. DCH will train single points of entry on the new tool and test it before applying it system wide	As part of evaluation, may have recommendations change I and A and OC standards. Use of LTCC materials by NF and Waiver not set in contract or requirements.			Streamline multiple eligibility processes		
	Recommendation #1, Strategy # 3 Require all Single Point of Entry agencies to establish and utilize person-center planning in their operations. Review and refine practice guidelines and protocols as part of the first year evaluation of the SPE pilot projects.						
	1. A system wide						

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	efficiency gain of 1.7% in LTC expenditures as a result of establishment of single points of entry will fund the entire state system. TF #3- number 10						
							Sec 1793 shall consider development of a pilot project that focuses

TOPIC Finance	Comments	LTC Commission Workgroup Activities	LTC TASK FORCE	Executive Order	SYSTEM TRANSFORMATION GRANT	ADRC/	Boiler Plate
			Recommendation # 9: Adapt Financing Structures that Maximize Resources, Promote Consumer Incentives, and Decrease Fraud. ***#2: Improve Access by Adopting "Money Follows the Person" Principles.***		**Goal 5: Create a system that more effectively manages the funding for long-term supports that promote community living options**		Sec 1775 study feasibility of using meanaged care to deliver Medicaid long-term care services: sufficient number of organizations interested, extent of services provided, estimate changes in ltc expenditures, report study June 1st, progress report June 1st
					Objective 1: Develop and implement a mechanism allowing flexible spending within the LTC budget consistent with consumer needs and preferences Strategy 1: Develop analysis, planning and forecasting capacity that supports annual		FY 2009 Dep App Legislative actions PA 246 of 2008Sec 1695 Shall evaluate the impact of implementing a case mix reimbursement system for nf. Progress report by August 1st.

					policy development, planning and budgeting for long-term supports • Use the analysis to develop a model to use to study results to forecast and develop an annual budget • Develop data analysis agenda • Identify data sources • Develop data reports • Build data reports and forecasts into annual long-term supports planning • Develop “what if” scenarios to project alternative trend lines and develop a shared interpretation of the merits of these scenarios • Develop liaison with legislative fiscal agencies and budget office • Identify and conduct special studies to identify key predictors of		

					successful community support for SPE consumers who are assessed at the NF level of care Strategy 2: Establish a unified state budget appropriation line for long-term supports which is flexible and meets changing needs. • Research methods used by states with single line items to manage their appropriation • Determine needs, costs and available resources, associated with nursing facility transition and single pointof entry referrals to long-term care programs (Complements DRA MFP grant.) • Involve budget office staff and key legislative staff in periodic briefings of data analysis and trends lines		
			Establish reimbursement levels that realistically and appropriately		**Objective 2:**		

			reflect the acuity level and need for services and supports the client needs, consistent with federal limitations. (An immediate step would be to remove the current reimbursement cap on the MI Choice waiver.) TF #2		**Develop and implement more effective payment methodologies** Strategy 1. Develop risk adjusted payment models for all long-term care programs • Obtain information about case mix payment systems in other states • Complete pilot tests and budget analysis of the payment method • Conduct a study of Home Help Program (state plan personal care) individuals eligible for nursing facility level of care • Examine options for including high-needs state plan personal care into a risk adjusted model for agency provider payments • Develop and implement Medicaid policy that assures		

					that the assessment produces a risk adjusted payment for all SPE Medicaid eligible consumers for all programs		
			TF:# 4; Ideally SPE would have one eligibility tool		**Strategy 2. Using a single integrated assessment** instrument, addressed under Goal 1, develop and implement a model that assigns risk adjusted payment rates that apply to all long-term care options • Review other states experience on developing and implementing risk adjusted payment methodology • Define the elements from assessment tool that contribute to a risk adjusted payment methodology • Develop methodology to	**Improve access to publicly funded services and supports by streamlining financial eligibility and consolidating functional assessment processes.** **ADRC grant Goal 3** Objective Create efficiency in financial eligibility determination process Create efficiency in functional assessment process.	-

					weight elements • Identify contractor to develop case mix methodology • Develop methodology to transition facilities to new rate system		
					Strategy 3. Develop approaches that support implementation of pilot(s) pre-paid health plan models for long-term care. (Complements 2003 RC MFP grant.) • Develop and submit a Request for Proposal • Implement prepaid long-term health plan pilots • Coordinate and transition pilots from MFP grant. • Using data and outcomes from the MFP pilots, review and modify policy principles to provide a base for development of statewide prepaid long-term care		

					health plan options of MFP and person centered planning		
		1.	2. Michigan should decouple its estate tax from the federal estate tax to make more revenue available. TF #9 3. Michigan should identify sources of non-federal tax revenue that are utilized to provide LTC and support services for Medicaid consumers, and create policies and procedures that will allow these funds to be used as local match to capture additional federal Medicaid dollars for long-term care and supports TF #9 4. The Michigan Congressional Delegation should: a. Advocate for the removal of the congressional barrier imposed on the development of Partnership program by states between Medicaid and long-term care insurance. b. Strongly advocate that the federal government assume full responsibility for the health care needs of individuals who are dually eligible for Medicare and Medicaid. c. Urge the Congress to revise the current Federal				

			Medical Assistance Percentage (FMAP) formula to a more just methodology using Total Taxable Resources or a similarly broader measure and to shorten the time frame from the data reporting period to the year of application. TF #9 5. Subject to appropriate reviews for actuarial soundness, overall state budget neutrality, and federal approvals, Michigan should establish a mandatory estate preservation program instead of establishing a traditional Medicaid Estate Recovery Program. TF #9 6. Legislation that promotes the purchase and retention of long-term care insurance policies and that addresses ratemaking requirements, insurance standards, consumer protections, and incentives for individuals and employers should be drafted, reviewed, introduced, and enacted after review by a representative group of consumers, advocates, and providers. TF #9 7. Three specific strategies aimed at increasing the number of people in Michigan who have long-term care insurance should be implemented: a) gain federal approval for the use of the Long-Term Care Insurance Partnership Programs.; b)				

			expand the state employees' self-funded, long-term care insurance program; and c) examine the possibility of a state income tax credit for purchase and retention of long-term care insurance. TF #9 8. Tax credits and tax deductions for the purchase of long-term care insurance 9. policies and for "out of pocket costs" for LTC should be considered. TF #9 10. A "special tax exemption" for taxpayers who provide primary care for an eligible parent or grandparent (and possibly others) should be explored. Based upon a $1,800 exemption proposed in legislation introduced in 2005, the Senate Fiscal Agency estimates cost to the state in reduced revenue at less than $1 million. TF #9 11. As an initial step, Michigan should adopt a Case-Mix reimbursement system to fund LTC services and supports. This approach sets provider rates according to the acuity mix of the consumers served. The higher the acuity, the higher the rate paid to the provider due to the resources needed to care for the consumers. As the long-term care system evolves, other appropriate funding mechanisms should also be considered and adopted. Michigan should encourage and strengthen local and regional programs that support caregivers in				

			their care giving efforts. **TF #9** 12. An ongoing and centralized data collection process by DHS of trusts and annuities information should continue to be used to guide the need for state regulation. **TF #9** 13. There should be ongoing review and strengthening, along with strict and consistent enforcement, of laws and regulations governing the inappropriate use of trusts and annuities for Medicaid eligibility. **TF #9** 14. There must be more frequent, vigorous, and publicized prosecution of those who financially exploit vulnerable individuals. **TF #9** 15. State agencies should cooperate in discovering and combating Medicaid fraud, and recovering funds paid for inadequate care. **TF #9** 16. New legislation for the regulation by the state of "trust mills" and annuity companies should be enacted. This legislation should address the prevention of abusive sales tactics through the implementation of insurance industry regulations, registration of out-of-state companies, and prescreening of sales materials. **TF #9** 17. Appropriate state agencies should analyze and quantify the relationship between public and				

			private resources, including both time and money, spent on LTC. This analysis should be used as a way to obtain a match for federal Medicaid dollars. **TF #9** 18. The state should study and pursue aggressive Medicare recovery efforts. a. . **TF #9** 19. The task force recommends full funding for an external advocacy agency on behalf of consumers accessing the array of supports and services overseen by the SPE system. Based on a conservative figure, the total budget line for this item would be $4.3 million. Of the increase, $2 million would be to bring the State Long-Term Care Ombudsman program into compliance with national recommendations; $2.3 million would go to the external advocacy organization TF #9				
		20.	21. Medicaid eligibility policies should be amended to: b. Permit use of patient pay amounts for past medical bills, including past nursing facility bills. c. Require full certification of all Medicaid nursing facilities. **TF #9**		~~1. .~~		
					~~2.~~		

			Establish consistent spend down provisions across all long-term care settings TF 2				
		3.	4. Establish funding mechanisms that abide by the "money follows the person" principle.TF 2				
		5.	6. Amend and fund the MI Choice waiver to serve all eligible clients. TF2				
			TF:# 4; Ideally SPE would have one eligibility tool				
			#2: Improve Access by Adopting "Money Follows the Person" Principles		**Goal 2:** **Increased choice and control: Develop and enhance self-directed service delivery system**		
	See PCP for objective and outcomes				Objective 1 Develop person-centered planning		
					Objective 2: Develop individual budgeting OUTCOMES: • State level guidance and criteria for budget development are applied across the LTC system. • Providers have the technical assistance		

					they need to support individual budgets. • Participants have the control they desire over their budgets. • Participants receive the support they need to develop and manage their budgets. • Budgets are sufficient to meet participant needs. • Budgets reflect the choices made through PCP.		
					Obj. 3Develop participant-employer options OUTCOMES Participants hire the providers they prefer. • Participants have the options and supports they need to manage their employees. • Participants and providers effectively use fiscal intermediaries. • Providers understand the consumers' role in employing and managing workers. • Payroll and employment tasks		

					are managed according to state and federal requirements.		
					Obj. 4Ensure self-directed supports OUTCOMES More “agency with choice” providers are available and used. • More independent supports brokers are available and used. • Participants report improved satisfaction with access, services, and outcomes		
					Obj 5.Promote Quality Assurance and Quality Improvement		